WORKFIRST - PUBLIC HEALTH
CHILDREN WITH SPECIAL NEEDS INITIATIVE

PUBLIC HEALTH NURSE (PHN) EVALUATION

DATE OF EVALUATION ☐ Initial ☐ Re-evaluation		
PARENT/GUARDIAN'S NAME		JAS IDENTIFICATION NUMBER
CHILD'S NAME	BIRTHDATE	CHILD'S SOCIAL SECURITY NUMBER
HEALTH CONDITION/PRIMARY DIAGNOSIS		
ADDITIONAL DIAGNOSES/HEALTH CONCERNS (ATTACH ADDITIONAL PAGES IF NECESSARY)		
PRIMARY CARE PROVIDER'S NAME (PHYSICIAN/NURSE PRACTITIONER)		TELEPHONE NUMBER (WITH AREA CODE)

I. PROGNOSIS

- ☐ Short term................Care needs are expected to become less....................... Approximate duration: ____________
- ☐ Stable/chronic..........Care needs are expected to remain about the same ...... Approximate duration: ____________
- ☐ Variable ....Care needs are expected to vary .... Approximate duration: ____________
- ☐ Deteriorating............Care needs are expected to increase .... Approximate duration: ____________

II. CARE REQUIREMENTS (DESCRIBE SPECIAL CARE NEEDS, INCLUDING ANY ASSISTANCE AND/OR EQUIPMENT NEEDED)

A. ENVIRONMENTAL MODIFICATIONS

B. MOBILITY

C. FEEDING (INCLUDE SPECIAL FOOD PREPARATION)

D. SLEEP ISSUES

E. RESPIRATORY

F. TOILETING/PERSONAL HYGIENE

G. MEDICATIONS (DOSE, FREQUENCY, ROUTE)

THERAPIES/MEDICAL TREATMENTS	PROVIDER'S NAME	TELEPHONE NUMBER (WITH AREA CODE)
☐ Occupational therapy		
☐ Physical therapy		
☐ Speech/language therapy		
☐ Other (specify, i.e., nebulizer, etc.)		

II. CARE REQUIREMENTS (CONTINUED)

BEHAVIOR ISSUES/MANAGEMENT TECHNIQUES

RISK FOR DIFFICULT OR VIOLENT BEHAVIOR IN CERTAIN SETTINGS

BEHAVIOR MANAGEMENT CONSULTANT'S NAME	TELEPHONE NUMBER (WITH AREA CODE)

TRANSPORTATION ISSUES

Has the child ever been in a successful child care situation? ☐ Yes ☐ No Please explain:

III. OTHER CARE RELATED NEEDS (INCLUDING FREQUENCY OF MEDICAL, THERAPY AND OTHER APPOINTMENTS)

IV. SCHOOL

Is the child in school? ☐ Yes ☐ No	IF YES, NAME OF SCHOOL	TELEPHONE NUMBER (WITH AREA CODE)

Are the child's parents called frequently to school due to the child's condition? ☐ Yes ☐ No IF YES, FREQUENCY

DESCRIBE USUAL FOLLOW-UP TO CALLS FROM SCHOOL

Number of school days missed this year __________________ ; missed last year ______________(as reported by parent)

V. OTHER SERVICES

☐ Division of Developmental Disabilities (DDD)
☐ Family Resource Coordinator (FRC)
☐ Infant Toddler Early Intervention Program (ITEIP)
☐ Supplemental Security Income (SSI)
☐ Women, Infants, Children (WIC)
☐ Other (specify):
☐ Known to PHN: ☐ Yes ☐ No

VI. SUMMARY OF HOME VISIT (ATTACH ADDITIONAL PAGES IF NECESSARY)

VII. TRAINING/MODIFICATIONS/SPECIAL EQUIPMENT OR SERVICES NECESSARY FOR CHILD CARE

PUBLIC HEALTH NURSE'S NAME	COUNTY	
TELEPHONE NUMBER (WITH AREA CODE)	FAX NUMBER (WITH AREA CODE)	EMAIL ADDRESS

NOTE: IF DSHS CONTRACTED INTERPRETER WAS USED, PLEASE INCLUDE INTERPRETER'S FORM.

INSTRUCTIONS ON REVERSE SIDE.

INSTRUCTIONS FOR COMPLETING THE
PUBLIC HEALTH NURSE (PHN) EVALUATION, DSHS 10-254

The purpose of this form is to provide the necessary information to WorkFirst staff in a concise manner. In most counties, you may note that the WorkFirst Evaluation and Recommendation forms have been completed; if so, place a copy of each in the patient's file.

Explain medical diagnoses, treatments, and care needs in non-medical terminology as much as possible. avoid medical acronyms and abbreviations.

Headings are to be guidelines only. If you have additional information pertinent to the child, include it in Other Care Related Needs or the Summary of the Home Visit.

Enter date of the evaluation.

Check whether this evaluation is an initial evaluation or re-evaluation.

Complete the parent/guardian's name and JAS number. Enter the child's name, birthdate, and social security number.

Diagnosis: This may be a presumed diagnosis, even if you do not have medical records to verify it.

I. **Prognosis:** If this question is not easily answered, elaborate in the Care Requirements section. You may enter unknown or unsure.

II. **Care Requirements:** Complete only the appropriate sections. These sections are lettered so you may use the letters for reference in completing the Summary and Training Modifications sections.

   Behavior Issues: Include information about management techniques (such as reduced stimulation in the environment, structured setting or schedule) and perceived differences in behavior in certain settings.

   Transportation Issues: Dependence on Medicaid transportation, public transportation, or others for medical and therapy appointments. Reliability of personal car.

   Child Care: If the child has ever been in a successful child care setting, note what made that child care successful. If child care was unsuccessful, note reasons.

III. **Other Care Related Needs:** Note routine appointments as well as the frequency (and time involved) of other appointments. Note if the parent must accompany the child to therapy - physical therapy, occupational therapy, speech, etc.

IV. **School:** Note amount of parent's time required to respond to child's needs while in school. Also, note in this section (or in Other Care Related Needs) if the child has a one-to-one attendant or other assistance in school. Include name and telephone number of school nurse. Note the number of school days missed as reported by the parent.

V. **Other Services:** Check if the child is already known to the PHN, as well as other resources already being used by the family. Note the name and telephone number of the PHN and/or FRC who have worked with the family in the Summary of Home Visit box.

VI. **Summary:** Summary of evaluation with attention to issues that impact the child's and the parent's daily schedule. You may reference information in others sections of the evaluation using the letter (A, B, C, etc.) for section designation.

VII. **Training/Modification/Special Equipment:** Complete this with the information available to you. You may reference sections by letter or section title as done in Summary. There may be changes or additions if there is consultation with a child care provider.

   PHN signature, county, telephone number, and fax number. Include area code.

The WorkFirst Case Manager and the parent get a copy of this form.